SOPHIE GUELLATI-SALCEDO Ph.D.
HEALTH PSYCHOLOGIST

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Informed Consent (Revised 03/25/2020)

This document contains important information about the psychological services provided by Dr. Sophie Guellati-Salcedo. **Please read this information carefully** and feel free to ask any questions that you may have.

CONFIDENTIALITY

All information shared in this treatment is confidential. Therefore, information that you and/or your child provide during the course of treatment will be considered privileged. Please be aware, however, that there are exceptions to confidentiality:

- If you are deemed in danger of harming yourself or anyone else.
- If the therapist believes that a child is being neglected or abused.
- If an elder is being abused.
- If the client is a minor (under 18 years of age), the client does not have the legal right to keep therapy confidential from his/her parents. For the purpose of therapy, however, the parent may agree to grant the minor privacy in therapy.
- Allegations of sexual misconduct by a licensed health care provider must be reported to the Florida Department of Health.
- If a Release of Information Authorization has been signed by the appropriate parties. This permission can be revoked by you at any time in writing. All parties agree to take all reasonable measures to ensure confidentiality with any communication over the phone and/or Internet.

CLINICAL HYPNOSIS

If you elect to use hypnosis in the course of your treatment, please do so in consideration of the following information. Hypnosis is a form of treatment that may prove beneficial in terms of clinical improvement, but may also have certain risks associated with its use. These risks may include the experience of intense unwanted feelings, thoughts, or memories that are often a natural and important part of the therapy process. In addition, memory is imperfect and research has shown that there is no guarantee that all information revealed during or after hypnosis is factually accurate. Consequently, should you recall events that are grounds for legal actions, please be aware that many courts of law will not admit hypnotically refreshed memories as testimony. Therefore, without corroborating evidence to support your recollections, the use of hypnosis may be associated with the loss of some legal rights. If you have any concerns about possible legal situations, you are advised to consult with an attorney about the use of hypnosis prior to engaging in such services.

FINANCIAL AGREEMENT

Fees are payable at the time of service. Your fee per 60 minute session is $200. The fee for the initial session (90 minutes) is $280. An hourly surcharge of $20 will be applied for off-hours appointments (after 5:00 p.m.). Your regular fee will be charged for any additional professional services rendered at your request, such as phone contacts over 15 minutes, consultations with other professionals, etc. Preparation of special forms or reports will be billed at the rate of $150 per hour.

In case the assigned therapist is subpoenaed to testify in court regarding your case, an hourly fee of $250 will apply and require an initial retainer of $1,250.00.

Informed consent, cont.

We do not accept insurance, as a form of payment for services rendered. A detailed receipt will be provided upon request when all fees are paid in full. This receipt will contain all of the information necessary to submit a claim to your insurance company, should you choose to do so. Please be aware that insurance companies vary in their reimbursement for psychological services, and no amount of reimbursement is guaranteed. In addition, coaching services are not covered by insurance companies. If payment in full is not received within 30 days of the last session, collections procedures may be initiated.

We accept cash, check, bank transfers (e.g., Zelle), and online payments via PayPal. A convenience fee will apply to online payments (including the PayPal *Bill Me Later* option).

FINANCIAL POLICY

If you have insurance which provides coverage for this provider and this treatment, we would be happy to assist you in completing your claim forms if you provide us with a completed claim form. You are responsible for mailing it to the insurance company and tracking your reimbursement. We do not accept assignment of benefits, nor do we participate in managed care insurance plans (HMO's and PPO's). We will gladly discuss your proposed treatment with your insurance company if they call us and you provide us with a release. We do not call to request authorizations. You are responsible for the full fee regardless of your insurance company's reimbursement policies.

YOUR PAYMENT IS TO BE PAID IN FULL AT THE TIME OF EACH SESSION. FEES ARE SUBJECT TO CHANGE EVERY SIX MONTHS.

NO-SHOW AND CANCELLATION POLICY:

Your visit has been reserved for you. A 24-hour notice is required for cancellation or you will be charged a late cancellation fee equal to your session fee. We will now require valid credit card information to secure new appointments.

EMERGENCIES

This office is not equipped to offer treatment on an emergency or walk-in-crisis-intervention basis. In the event of a crisis you can:

- Go to the emergency room of the nearest hospital for an evaluation.
- Contact the Switchboard of Miami Crisis Hotline 305-358-4357 and speak with a counselor by phone.
- Contact Jackson Memorial Hospital (psychiatry) at 305-585-6487.

STATEMENT OF UNDERSTANDING

I have reviewed the information above and give consent for treatment. Further, I agree that I have been afforded the opportunity to discuss any questions about the terms of this agreement before signing below.

_____	_____	_____
Client's Name	Client's Signature	Date
_____	_____	_____
Parent or Guardian if minor	Signature	Date

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Authorization for Distant Card Payment

Client Name:_____

Amount of payment: (Amount of contractual session fee)_____

Name of the cardholder: _____

Billing Address: _____

_____

Zip Code: _____

Telephone:_____ Email address:_____

Type of card: ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS
Card Number: _____
Expiration Date (MM/YYYY): _____
Security Code (last 3 or 4 digits on back of card): _____

If you wish to receive copy of your receipt by return, please give us your email address and check the appropriate box below:

- ☐ Yes, I wish to receive copy of my credit card payment customer receipt.
- ☐ No, I do not wish to receive copy of my credit card payment customer receipt.

_____ _____
Cardholder Signature Date

This form will be destroyed immediately after completion of the transaction. However, your information will be kept on file until termination of psychological services.

THANK FOR YOUR PAYMENT